GENDER ANALYSIS OF THE COVID-19 PANDEMIC IN IRAQ

Conducted in Kirkuk, Diyala and Sulaimaniyah governorates

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In Iraq, as elsewhere, the coronavirus pandemic is having severe impacts on the population, but women and men are affected in different ways. This gender analysis shows that women in three sample areas of the country are facing an increase in the burden of domestic work and caring responsibilities, a heightened risk of GBV and particularly domestic violence, and greater loss of economic livelihoods difficulties in accessing health and support services, due to restrictions on movement and constrictive social norms, have limited decision-making power, and lack information on coronavirus itself, which could help keep them safe.
Executive Summary

In Iraq, as elsewhere, the coronavirus pandemic is having severe impacts on the population, but women and men are affected in different ways. The Oxfam gender analysis shows that women in three sample areas of the country are facing an increase in the burden of domestic work and caring responsibilities, a heightened risk of domestic and gender-based violence, and greater loss of economic livelihoods and autonomy. They also face greater difficulties in accessing health and support services, due to restrictions on movement and constractive social norms, as well as limited decision-making power, and lack of information on coronavirus itself.

In April and May 2020, Oxfam Iraq conducted a gender analysis to document the gendered impacts of coronavirus in Kirkuk, and Diyala and Sulaimaniyah. The methodology comprised of secondary data analysis and primary data collection. Quantitative data was collected using a survey questionnaire administered via phone calls to 207 individuals. Qualitative data was collected through 20 key informant interviews. Validation workshops were organised with Oxfam in Iraq staff and partners to further analyse the findings.

The situation of Iraqi women was already precarious before the pandemic. Years of socio-economic and political instability have led to a deterioration in the rights, well-being and representation of women in Iraq. The results of the gender analysis confirm these worrying trends: **women and girls are more at risk and withstand more pressure during this pandemic.**

**Women bear most of the burden of cleaning the house, preparing food, and taking care of children and sick people.** While women used to spend on average more than six hours a day performing unpaid activities, their burden is likely to increase due to the COVID-19 pandemic.

**Women and girls face increased risks of violence during the pandemic.** With most incidents of gender-based violence occurring in the home, the lockdown is likely to put women at increased risk of violence. A majority of the interviewees think that women and children are facing increased protection risks as a result of the coronavirus pandemic. However, GBV survivors lack access to the support they need.

**Women have less access to information on COVID-19 than men and are more likely to be unable to protect themselves from the disease.** While most respondents felt suitable informed about COVID-19 guidelines, from watching TV or social media, many felt they were unable to carry out the preventative measures due to lack of resources to purchase the necessary items.

**Women’s incomes and livelihoods are more affected by coronavirus prevention measures than those of men.** Between 15 and 30% of the women surveyed had some form of economic activity before the crisis. Most of them were not able to maintain this since the outbreak.

**Access to sexual and reproductive health services is extremely limited, putting women at risk of mortality and morbidity that could otherwise be avoided.** A shortage of contraceptive supplies, fear of contracting the virus in the health facilities and movement restrictions are among the key factors impacting women’s sexual and reproductive health during the pandemic.

**The current pandemic presents unprecedented challenges for women’s health, livelihoods, safety and representation.**

We call on public authorities and humanitarian actors to protect women from physical, psychological and economic violence, to enhance their participation in the COVID-19 response and to provide gender-sensitive interventions.
Women bear most of the burden of cleaning the house, preparing food, and taking care of children and sick people. Their unpaid and domestic work is likely to increase due to the COVID-19 pandemic.

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Background

Cleaning the house, preparing food, caring for children, sick people, and elderly people, and finding fuel and water are all part of the reproductive and domestic work that is almost exclusively the responsibility of women. Iraq has seen increased participation by women in the labor market (12.4% in 2019 compared with 9.6% in 2000), but this has not led to men taking on more care responsibilities and so has resulted in a double burden for women and girls. Iraqi women workers are mostly employed in the public sector and are therefore under-represented in the informal sector (except in agricultural work in rural areas). However, their access to the labor market is limited and precarious and many of them will most likely be affected by the pandemic, losing their jobs or being forced to accept unfair work conditions. Across the world, confinement, loss of income, and lack of economic resources exacerbate tensions in the household and can lead to the perpetration of violence against women. Women’s rights activists in China, for example, have reported that cases of domestic violence have risen dramatically during the COVID-19 lockdown. Helplines for survivors of gender-based violence (GBV) have seen an increased volume of calls in Spain, France, and Singapore. Restrictions on movement prevent women who are living with an abusive partner from leaving their houses to avoid violence or to seek help, and services available to GBV survivors are limited due to the lockdown.

During crises such as the coronavirus pandemic, women continue to have sexual and reproductive health needs, such as safe delivery, antenatal consultation, and contraception. During the outbreak of Ebola virus disease in West Africa in 2014–16, some service providers suspended their activities across the region. This restricted access to maternal health clinics and led to maternal mortality rates increasing by 70%. A lack of family planning services also increases the risk of unplanned pregnancies, with impacts on maternal mortality. According to global projections by the United Nations Population Fund (UNFPA), 47 million women in 114 low- and middle-income countries may not be able to access modern contraceptives and 7 million unintended pregnancies are expected to occur if the lockdown carries on for 6 months and there are major disruptions to health services.

In Iraq, years of repression caused by a strongly conservative culture, economic sanctions, and armed conflicts have led to a deterioration in the quality of lives of women and an associated loss to the country, since women are marginalized and unable to fully contribute economically, socially, or politically. Iraq has an estimated population of more than 40 million. Women comprise half of the total population and head one in 10 of Iraqi households; 80% of these female household heads are widows. Iraq is one of the most youthful countries in the world, with 58% of the population less than 24 years old (11,981,412 males and 11,503,888 females). The country’s economy is mostly state-run, with over 90% of government revenues and 60% of gross domestic product (GDP) coming from the oil sector, which will affect all aspects of life in the country. The oil sector, however, employs only 1% of the total labor force. Iraqis remain highly dependent on the public sector, which provides around 60% of employment. Just 18% of women are employed or are looking for employment, and they account for only 7% of employment in non-agricultural sectors. Iraq was ranked 120th on the UN Human Development Index and on the UN Gender Inequality Index in 2018.

According to the World Health Organization, as of 7 June 2020, a total of 12,366 people in Iraq had been infected by COVID-19, of whom 44% were female. Although COVID-19 mortality rates have so far been higher for men than for women, women are more likely to be affected in other ways by the virus and its consequences.
After years of war, Iraq is facing a new wave of social unrest fueled by the deterioration of social and economic infrastructure, disruption of the social fabric, and increased dependence on oil revenues. The COVID-19 pandemic may have paused political protests for the moment but they are likely to resume, if not increase, in the current context of a worsening economic situation.

Oxfam in Iraq began its response to the COVID-19 pandemic in early April 2020. The overall goal of its response is to ensure that vulnerable communities receive adequate, inclusive, and safe support to:

- reduce the infection risk in the coronavirus outbreak;
- mitigate the risk of GBV and have access to appropriate services;
- be protected from the negative socio-economic impacts of the pandemic.

In order to inform its response, and to ensure that gender is adequately mainstreamed in all its activities and programs, Oxfam in Iraq has conducted a gender analysis to document the gendered impacts of coronavirus in three governates where it is implementing programs, namely Kirkuk, Diyala, and Sulaimaniyah.

Kirkuk is a governorate situated in northern Iraq, with an area of 9,796 km² and a population of nearly 1.6 million people. It can be seen as a microcosm of the country, with diverse ethnic groups (Kurdish, Arab, and Turkmen) and religious groups (Sunny, Shi’ia, Chaldean, Assyrian). Its diversity, its geographic location, and its rich oilfields have made it a highly contested area between different ethnic communities, as well as political authorities, and its control remains disputed between the Government of Iraq and the Kurdistan Region of Iraq (KRI). Kirkuk, its capital city, is highly urbanized and has historically always had an important place on the commercial map of the region and the country as a whole.

The governorate of Diyala is located in eastern central Iraq, bordering Iran and occupying an area of 17,685 km². Diyala has a diverse population of Arabs, Kurds, and Turkmen with a total of 1.1 million people. Like Kirkuk, Diyala is part of the territories disputed between the Iraqi government and the KRI. The governorate has vast swathes of agricultural land, along with some oil, but suffers from poor infrastructure and from limited water supplies.

The governorate of Sulaimaniyah, located in the northeast of Iraq on the border with Iran, has an area of 17,023 km² and a population of 1.7 million. It is part of the KRI and the majority of its inhabitants are ethnic Kurds. The Sunni branch of Islam is the dominant religion in Sulaimaniyah, but the governorate is also home to Shi’ite Kurds and a number of Chaldean Christian communities. Sulaimaniyah benefits from a stable security situation, and has therefore been able to attract foreign investment and domestic tourism.

Exploring the situation of the people with whom Oxfam works, who are a particularly vulnerable population, this research aims to uncover the impacts of COVID-19 and the response to the epidemic, rather than providing a holistic analysis. More specifically, this gender analysis has the following objectives:

- To explore the different vulnerabilities, needs, capacities, and aspirations of women, men, boys, girls, and people with disabilities due to the COVID-19 pandemic.
- To inform the effectiveness and relevance of Oxfam’s sector-specific response to the pandemic, in line with existing and planned gender justice programming.
- To provide recommendations for adapting Oxfam’s COVID-19 response to meet the specific needs of women, men, girls, and boys.
This COVID-19 gender analysis was conducted in April and May 2020 in Kirkuk, Diyala, and Sulaimaniyah governorates.*

The Oxfam in Iraq gender team applied a combined methodology comprising:

- Secondary data analysis through a desk review of research and reports around gender equality in Iraq before the coronavirus pandemic, gender and other public health emergencies (such as Ebola), the gendered impact of COVID-19 globally and regionally, and Iraq’s response to the coronavirus.

- Primary data collection:
  - Quantitative data were collected using a survey questionnaire administered via phone calls at individual level. A total of 207 individual interviews were conducted (100 in Kirkuk, 80 in Diyala, and 27 in Sulaimaniyah).*
  - Qualitative data were collected through 20 key informant interviews (KIIs) (10 in Kirkuk, five in Diyala, five in Sulaimaniyah).*
  - Validation workshops with Oxfam in Iraq staff and partners, which provided some important insights on the findings.

Prior to data collection, 12 enumerators (8 female and 4 male) were trained on the use of mobile devices for quantitative data collection and on the survey and KII questions. A pilot of the survey questionnaire was carried out by the gender team and the tool was revised based on feedback from the field.

* Due to movement restrictions imposed by the authorities to prevent coronavirus infection, direct access to communities was not possible. Data collection had to be done through phone calls, which limited interactions with respondents, especially during KIIs. For the same reason, it was not possible to organize focus group discussions. Validation workshops were organized with the field teams to address this limitation and to collect their inputs to analyse the compiled data. Training and supervision of data collectors were also done remotely and in a short period of time, which posed challenges in ensuring the quality of the data. Triangulation of data allowed the team to partially overcome this challenge.
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The sample for quantitative data collection was taken randomly from Oxfam’s database of the people it had worked with in previous interventions. Within the limits of the data available in the Oxfam database, the team selected a balanced sample representing different categories of the population. As the database does not include all characteristics of the people with whom Oxfam works in Iraq, some categories may be over- or under-represented.

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**ETHICAL CONSIDERATIONS**

All activities involved in this study took research ethics into consideration. A detailed description of the main study objectives was provided, and informed consent was sought from all respondents involved in the collection of primary data. Respondents were informed that they were entitled to stop responding or participating in the study at any time they wished. Participants were invited to renew their consent before answering questions relating to GBV at the end of the survey.

**LIMITATIONS**

Due to movement restrictions imposed by the authorities to prevent coronavirus infection, direct access to communities was not possible. Data collection had to be done through phone calls, which limited interactions with respondents, especially during KIIs.

For the same reason, it was not possible to organize focus group discussions. Validation workshops were organized with the field teams to address this limitation and to collect their inputs to analyse the compiled data.

Training and supervision of data collectors were also done remotely and in a short period of time, which posed challenges in ensuring the quality of the data. Triangulation of data allowed the team to partially overcome this challenge.
In Kirkuk, 59% of survey respondents were female and 41% were male. Just over half (52%) were aged 26–40, 22% were aged 40–50, 20% were aged 18–24, and 6% were over 50 years old. Of the respondents, 54% reported that they were married, 20% that they were not married, 16% that they were widowed, and the remaining 10% that they were divorced. Women accounted for 55% of unmarried respondents, 90% of divorced respondents, and 94% of widowed respondents. Of respondents from Kirkuk, 86% live in an urban setting, with 8% living in semi-urban settings and 6% in rural settings; 68% live in a male-headed household and 32% in a female-headed household; 60% of respondents are displaced, 36% are ‘remainees’, and 4% have returned to their community after being displaced; 39% of households have a member with a disability, and 54% have a member with a chronic disease.

In Diyala, 61% of survey respondents were female and 39% were male; 42% were aged 26–40, 34% were aged 40–50, 15% were over 50, and 9% were aged 18–24. Of the respondents, 76% reported that they were married, 13% that they were widowed (90% of these being female), and 11% that they were not married (78% of them female); 38% of respondents live in urban settings, 36% in rural settings, and 26% in semi-urban areas; 75% live in a male-headed household, with the remaining 25% living in a female-headed household; 62.5% of respondents are returnees, 20% are remainees, and 17.5% are displaced; 12.5% of households have a member with a disability, and 50% have a family member with a chronic disease.
Demographic Information

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In Sulaimaniyah, 48% of survey respondents were female and 52% were male; 41% were aged 40–50, 33% were in the 26–40 category, 22% were 50 and above, and 4% were 18–24 years old. Of the respondents, 74% reported that they were married, 11% were widowed (all of them female), and 15% were not married (75% of these being female); 78% of respondents live in urban settings, and 22% in semi-urban areas; 81% live in a male-headed household, and 19% in a female-headed household. A large majority of respondents are remainees (93%), with 7% being displaced; 19% of households have a member with a disability, and 63% have a member with a chronic disease. Household characteristics are presented in the figures below.

Gender Analysis of the COVID-19 Pandemic in Iraq
Men work outside of the home, and the harder part of the duties is on men. Women are at home doing household work, performing a complementary role. I work, and my wife takes care of the children, cooks, and does all the household work.

‘Now men have more time at home as they are not going out. So, they can be supportive with household chores. I am a teacher, I didn’t use to stay at home. But now I take care of my children.’

Sulaimaniyah, community leader, male, 36 years old, April 28, 2020
Men and boys are responsible for earning a living and for protecting their family, women and girls are responsible for taking care of the family inside the house.

These words from a 47-year-old male community leader in Diyala governorate illustrate the division of roles and responsibilities between women, girls, men, and boys. The International Labour Organization (ILO) estimates that ‘globally, women perform 76.2% of the total hours of unpaid work, more than three times as much as men.’ In Iraq, women spend on average more than six hours a day performing unpaid activities and devote 10.5 weeks per year more than men to such unrecognized work.

Women bear most of the burden of cleaning the house, preparing food, and taking care of children and sick family members.

Eight out of 10 respondents in Kirkuk reported that women and girls were responsible for keeping the house clean, preparing food, and taking care of children and/or people who are ill. A similar pattern was observed among respondents in Diyala, where 92.5% of respondents said that women and girls were responsible for keeping the house clean and preparing food. Likewise, 81% said that caring for children and/or sick people was the responsibility of women and girls. Among respondents in Sulaimaniyah, 78% said that keeping the house clean and preparing food were the responsibility of women. However, 41% said that caring for children and/or sick family members was a shared responsibility within the family.

Men and women share the burden of shopping for food, except in female-headed households.

More than half of respondents in Kirkuk (54%) said that shopping for food and other household items was the responsibility of men and boys. Among the remaining 46% who said that women were responsible for shopping, two-thirds of households were female-headed. In Diyala, three out of four of respondents said that going out for shopping was the responsibility of men and boys; female-headed households accounted for half of the remaining quarter. In Sulaimaniyah, 74% said that shopping for food and other household items was done by men and boys. Of the 26% of households where women were responsible for shopping, half were female-headed. Women and girls are responsible for most of the domestic work, and their workload is likely to have increased during the pandemic, either to implement prevention measures (‘We clean the house more’) or to take care of their families (‘Men at home may have more demands’). The survey does not clearly demonstrate such an increase, but it was identified by several key informants; this may be due to the invisibility of women’s unpaid care and domestic work. Although it might be too early to observe any long-lasting changes in social norms, several key informants said in their interviews that, with men spending more time at home, some of them were beginning to contribute to domestic chores, mainly by taking care of their children.
‘Violence against women and girls: the shadow pandemic’  

According to worldwide projections by UNFPA, ‘31 million additional cases of gender-based violence can be expected to occur if the lockdown continues for at least 6 months. For every 3 months the lockdown continues, an additional 15 million extra cases of gender-based violence are expected.’  

In Kirkuk, more than seven out of ten respondents thought that women and children faced increased protection risks as a result of the coronavirus pandemic. Emotional abuse (84% of respondents), economic violence (78%), and physical violence (65%) were the main risks reported. The risk of sexual violence was reported by 6% of respondents. In Diyala, half of respondents thought that women and children faced increased protection risks because of the pandemic. The three main GBV risks identified by respondents were physical violence (29%), economic violence (18%), and forced marriage (14%). In Sulaimaniyah, about two-thirds of respondents thought that women and children faced increased protection risks. The three main GBV risks identified were economic violence (38%), physical violence (31%), and emotional abuse (23%). Findings from the primary collection of data are consistent with several sources which are showing an increase of GBV. In a recent assessment the GBV Sub-Cluster evidenced that ‘65% of service provision points reported an increase or exacerbation in one or more of GBV types in their areas of intervention during the COVID-19 outbreak’. A large majority (94%) of the increase are cases of ‘domestic violence reportedly perpetrated by a spouse or other family member/s within the household’. Diyala and Kirkuk governorates are among the four governorates where the highest numbers are reported. 

The report also stresses that the ‘Iraq Information Centre (IIC) received a higher number of calls reporting GBV incidents during the lockdown in March and April (approximately 44% higher compared to the previous months). Almost all calls were about domestic violence.’ According to a rapid assessment of the response of health services to GBV survivors during the coronavirus emergency carried out by the health cluster, 40% of health service providers surveyed indicated an increase in the number of women survivors of violence seeking help during the pandemic, with domestic violence accounting for the majority of cases. Several key informants explained to Oxfam that the increase in GBV, and especially physical violence in the household, was attributable to the fact that men are not used to staying at home and can no longer go out to work or to socialize. Confine ment and economic hardship increase stress, frustration, and anger among men, who then become violent towards their families. The words of one key informant [male, age 36] illustrate this situation: ‘Men have little patience. […] Before, when men got angry they could go out and after a while forget about the issue, but now they can’t go out and [they] have to stay together, and that creates more tension.’ Alarmed by the increase in domestic violence due to the pandemic, in April 2020 four UN agencies issued a statement to urge the Iraqi Parliament to speed up its endorsement of the Anti-Domestic Violence Law. This law has been blocked in parliament since 2019. 

One in five Iraqi women and girls (21%) aged 15–49 were subjected to physical domestic violence in 2008. In a 2012 survey, 73% of women aged 15–45 reported that the perpetrator of domestic violence was their husband, followed by their father (53%), then other family members (43%). With most incidents of gender-based violence occurring in the home, lockdown measures to prevent the transmission of coronavirus are likely to put women at increased risk of violence.
In Kirkuk, eight out of 10 women surveyed for this analysis believed that there was an increased risk of violence during the coronavirus pandemic. However, among these women, three out of five did not know where to report violence or to obtain information on services for victims of violence. Similarly, 52% of women respondents in Diyala and 62% in Sulaimaniyah thought that the pandemic was increasing the risk of violence against women and girls. In Diyala, more than nine out of 10 of women respondents said that they did not know where to get support if violence occurred. In Sulaimaniyah, seven out of ten women respondents said the same.

According to the GBV Sub-Cluster, the number of people reached with GBV-related activities declined in March/April compared with January/February as a consequence of the lockdown. Case management and psychosocial support activities decreased by 25–50% and awareness-raising activities by 60%. This is similar to patterns seen elsewhere in the region, with victims of violence going into survival mode and preferring to keep silent due to the lack of any alternative. In April the easing of restrictions allowed some actors to resume their activities and some women’s centers to reopen. Overall, however, major gaps in GBV services remain due to a chronic lack of funding and the current impact of the pandemic. As of April 2020, the GBV response had achieved only 10% of the targets set out in the Humanitarian Response Plan 2020.

In the three governorates targeted by this gender analysis, different services are available for GBV survivors, including women’s centers, case management, psychosocial support, clinical management of rape cases, and legal support. However, service providers cover only specific locations and do not reach the whole of the governorates, and this poses challenges in terms of access and referrals. Sulaimaniyah governorate has only one shelter for women, and Diyala and Kirkuk have none at all.

Victims of violence in federal Iraq can obtain support by calling a hotline on 139. In Kurdistan, the hotline number is 119. However, a large majority of the women who responded to the survey were not aware of these hotlines and said that even if they had known about such services, they would not use them.

According to Oxfam’s data collection team, most respondents who said that they would not use the GBV hotlines operated by the authorities were concerned about the lack of confidentiality. Quantitative data on the increase in GBV in Iraq are not yet available. However, the perceptions of survey respondents on the risk of GBV and the KIIs indicate that an increase in violence against women and girls is likely. A representative of a woman’s rights organization [WRO] (female, age 50) said during her interview: ‘We notice through social media and according to the cases we receive through our networks that violence has increased towards women and girls.34 Meanwhile, the availability of services and access to them is made extremely difficult by restrictions on movement introduced during the pandemic. A woman living with an abuser cannot leave her house to avoid violence or to seek support from relatives, NGOs, or the authorities. Services offered to GBV survivors are also limited, with women’s centers closed and service providers forced to switch to remote provision of services, which limits the quality and diversity of services available. In its Situation Report of 28 April, OCHA noted that ‘overall protection programming has been hampered by the lack of access due to movement restrictions and associated measures such as closure of community centers and relevant government offices’.35 Sexual and reproductive health services (which are a key entry point for the identification of GBV survivors) and GBV services are also likely to be limited as resources are pulled towards the coronavirus response. The consequent lack of support for GBV survivors and other vulnerable people could partially explain the increased number of suicides reported in some communities. According to one key informant (female, age 50): ‘In Diyala a lot of suicides have occurred in the last 20 days’.36 A similar trend has been observed in Kirkuk where, according to reports, seven women took their own lives in the first four months of 2020, five of them during the national coronavirus lockdown.37 According to the GBV Sub-Cluster assessment, ‘123 GBV-related suicide attempts or incidents were reported involving women and girls’. Diyala and Kirkuk governorates are among the three governorates with most reported cases. The COVID–19 Strategic Response Plan for Iraq considers the provision of mental health and psychosocial support (MHPSS) to be a priority, observing that in times of crisis women and children experience such stresses more often and that in Iraq there are currently a high number of cases of GBV and many survivors in need of MHPSS.38 However, the health system’s capacity to address the MHPSS needs of the population is extremely limited. With only 34 outpatient facilities and three mental hospitals,39 Iraq faces a severe shortage of trained mental healthcare professionals40 (with 0.4 psychiatrists, 0.1 psychologists and 0.2 social workers per 100,000 of the population).41 Overwhelmed staff lack the time to provide adequate care to mental health patients and thus overly rely on the prescription of drugs.

Figure 9: Knowledge about and use of GBV hotlines
Women have less access to information than men

Women’s access to information is defined by a number of factors. Of the 3.3 million people in Iraq who are illiterate, 2.3 million are women, and this restricts their access to written documents. Gender norms and cultural factors also influence the access of women and girls to information. For instance, according to earlier research done by Oxfam in Kirkuk, 70% of women tend to find out about services or assistance available in their area through neighbors or by word of mouth. In further research conducted in Diyala and Kirkuk governorates, Oxfam found that women mainly rely on information received from family members, especially husbands or parents, to form an opinion.

The same research shows that women’s use of new technologies remains limited, and in some communities women and girls are not allowed to use social media platforms such as Facebook. These findings illustrate the digital gender gap in Iraq, where 98% of men have access to the Internet compared with just 51% of women.

All respondents interviewed in Kirkuk, Diyala, and Sulaimaniyah had heard about COVID–19, and most key informants identified age and a weak immune system as major risk factors for coronavirus. However, misconceptions and rumors were still common. One female key informant stated that her daughter-in-law could get the disease from her animals; some people believed that coronavirus leads to male infertility; and some segments of communities played down the risk of COVID–19, believing that it did not exist or that it could be prevented by using herbs or ginger or by visiting holy places.

‘For COVID–19, information is shared through all means of communications and media. The matter is more about whether people believe or not.’

If someone doesn’t want to shake hands, people will say something like “Are you afraid of this virus?” and make fun of him.'
Women obtain their information from TV while men get theirs from the internet

In Kirkuk, two-thirds of respondents got their information about the virus from television (73% of females and 58% of males). The second most common source of information was the Internet, with a little under one-third of respondents (15% of females and 34% of males) getting information this way. For women, the third-ranked source of information was their neighbors, while for men it was NGOs.

In Diyala, TV was the main source of information for eight out of ten women and seven out of ten men. The second most common source of information for men was the Internet (for half of male respondents), and for women their neighbors (one-quarter of female respondents). In Sulaimaniyah, more than nine out of ten respondents (equal numbers of women and men) got their information on coronavirus from TV. The second most common source of information was the Internet (for half of male respondents), and for women their neighbors (one-quarter of female respondents).

These results confirm findings from the previous Oxfam research conducted in Kirkuk and Diyala, which indicated high levels of TV ownership (100% for households interviewed in Diyala and 65% for households in Kirkuk), making TV the most used source of information in many homes and especially for women. Radio is mainly listened to in cars, by men. As the lockdown has limited movements by car, opportunities to listen to the radio are scarce.

Women know about prevention measures but some are unable to implement them for financial reasons

A large majority of respondents said that they knew the prevention measures against coronavirus and were able to implement them.

However, of those who cannot implement prevention measures, most are women. The main reason given for not being able to implement prevention measures was a lack of money to purchase the necessary items (like soap, alcohol, chlorine, or other disinfectants). Some respondents also reported that these products were unavailable in their area or that they could not go out to buy them.

Field staff have also observed a change in communities’ reactions towards coronavirus: while at the beginning of the pandemic people were afraid and implemented the prevention measures, they have become less compliant over time.

Vulnerability to coronavirus is seen differently by women and men

One in four of respondents in Kirkuk said that someone in their household was particularly vulnerable to coronavirus. The two main types of vulnerability identified by respondents were physical factors (existing medical conditions and co-morbidities, vulnerabilities mainly stated by women) and social factors (the person in charge of doing the shopping, a vulnerability mostly stated by men).

In Diyala and Sulaimaniyah, about one-third of respondents considered that someone in their household was particularly vulnerable to coronavirus. People leaving the house (either men for shopping or work, and children for play) were seen as the most vulnerable, along with persons with diseases or poor immune systems and older people.

Several key informants pointed out that men and boys were more likely not to respect the lockdown and to go out to visit friends. One (female, age 41) explained: ‘Men and boys are at risk of contracting COVID-19 because they are meeting with others and gather in a house to play games, smoke hookah, and chat, and that will affect other members of their families.’

Figure 10: Knowledge and implementation of coronavirus prevention measures

[Bar chart showing the percentage of respondents who know and implement prevention measures of coronavirus in Kirkuk, Diyala, and Sulaimaniyah by gender]
Decision making and leadership

Women are less involved in decision-making processes

In Kirkuk, half of respondents said that they had not been involved in discussions or decision-making processes relating to coronavirus in their communities. Three-quarters of these were women.

In Diyala, seven out of ten respondents said that they had not been involved in discussions or decision-making processes (71% of them were women), as did eight out of ten respondents in Sulaimaniyah (59% of them were women).

Key informants confirmed that women were not usually included in decision making related to coronavirus; one interviewee (male, age 39) reported: ‘Nearly all of the emergency cell committees are composed of males and members of the security forces.’ Women’s rights organizations have a great deal of knowledge and expertise on women’s capacities and needs, but one female WRO representative said in a KII: ‘They just asked us to cooperate as a civil society organization and provide what support we could for the most vulnerable families, but the decisions are taken by the crisis cell in Diyala, which consists of the governor, the police, and the health directorate.’

For four out of ten of respondents in Kirkuk, decision making relating to the coronavirus outbreak was a shared responsibility within the family, although in 2 out of 10 cases decisions were taken by the husband alone. Of the remaining cases where decision making was a responsibility for women, eight out of ten were female-headed households.

In Diyala, 45% of respondents said that coronavirus decision making was a shared family responsibility, while 32.5% said that it was the sole responsibility of the husband. In the remaining 22.5% of cases it was the responsibility of women; 61% of these were female-headed households.

A similar pattern was observed in Sulaimaniyah, with 59% of respondents sharing responsibility for decision making around coronavirus, and 22% saying that it was the man’s responsibility. In 19% of cases women were responsible, but 60% of such cases were female-headed households.

The government, emergency cell committees, and local government health directors are all responsible for making decisions and leading the COVID-19 response.

“[Women and men are not participating in the design of the response] as the government is the one making decisions.”

Decision making in the family is the responsibility of men, except in female-headed households

In Kirkuk, one in 10 respondents did not have access to clean water, all of them were women. Although a large majority had access to soap, only 57% had access to other hygiene products (such as alcohol, chlorine, or other disinfectants). Of the 43% who did not have access to hygiene products, eight out of ten were women, all of whom said that they did not have the financial resources to buy such items.

In Diyala, 16% of respondents did not have access to clean water, and half of these were women. Most respondents had access to soap, but more than a quarter were lacking other hygiene products, seven out of ten of these were women. A large majority of respondents said that they lacked disinfectant products because they had insufficient financial resources to buy them.

Two out of ten of Sulaimaniyah’s respondents lacked access to clean water; a third of them were women. All respondents reported having access to soap and only one in ten do not have access to other hygiene products.

Variable access to menstrual hygiene products

A large variation was found between governorates in women’s access to sanitary pads. In Kirkuk 17% of women respondents did not have access to such products. Of these, 90% were displaced or returnees, and 50% lived in a male-headed household.

In Diyala, 53% lacked menstrual hygiene products, with 77% being displaced or returnees and 65% living in a male-headed household.

In Sulaimaniyah, on the other hand, all female respondents said that they had access to such products. It is worth mentioning that in Sulaimaniyah most respondents live in urban and semi-urban settings, where access is easier.
In Kirkuk, half of respondents said that they had not been involved in discussions or decision-making processes relating to coronavirus in their communities. Three-quarters of these were women. In Diyala, seven out of ten respondents said that they not been involved in discussions or decision-making processes (71% of them women), as did eight out of ten respondents in Sulaimaniyah (59% of them women). Key informants confirmed that women were not usually included in decision making related to coronavirus; one interviewee (male, age 39) reported: ‘Nearly all of the emergency cell committees are composed of males and members of the security forces.’

Women’s rights organizations have a great deal of knowledge and expertise on women’s capacities and needs, but one female WRO representative said in a KII: ‘They just asked us to cooperate as a civil society organization and provide what support we could for the most vulnerable families, but the decisions are taken by the crisis cell in Diyala, which consists of the governor, the police, and the health directorate.’

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A similar pattern was observed in Sulaimaniyah, with 59% of respondents sharing responsibility for decision making around coronavirus, and 22% saying that it was the man’s responsibility. In 19% of cases women were responsible, but 60% of such cases were female-headed households.

The government, emergency cell committees, and local government health directors are all responsible for making decisions and leading the COVID-19 response. [Women and men are not part of the design of the response] as the government is the one making decisions.

In Kirkuk, one in 10 respondents did not have access to clean water, all of them women. Although a large majority had access to soap, only 57% had access to other hygiene products (such as alcohol, chlorine, or other disinfectants). Of the 43% who did not have access to hygiene products, eight out ten were women, all of whom said that they did not have the financial resources to buy such items. This finding was consistent with women being unable to implement prevention measures as they were unable to buy the necessary items.

In Diyala, 16% of respondents did not have access to clean water, and half of these were women. Most respondents had access to soap, but more than a quarter were lacking other hygiene products, seven out of ten of these were women. A large majority of respondents said that they lacked disinfectant products because they had insufficient financial resources to buy them.

Two out of ten of Sulaimaniyah’s respondents lacked access to clean water; a third of them were women. All respondents reported having access to soap and only one in ten do not have access to other hygiene products.

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In Diyala, 53% lacked menstrual hygiene products, with 77% being displaced or returnees and 65% living in a male-headed household.

In Sulaimaniyah, on the other hand, all female respondents said that they had access to such products. It is worth mentioning that in Sulaimaniyah most respondents live in urban and semi-urban settings, where access is easier.
In a recent briefing, Oxfam estimated that the economic fallout from the coronavirus pandemic could push half a billion more people worldwide into poverty. According to UN Women, 1.7 million people in the Arab region could lose their jobs, including 700,000 women. In Iraq, 87% of women aged 15 and above are not participating in the formal labor force, and as a result are particularly at risk of poverty. Women may not only lose their income-generating activities but may also face greater difficulty in resuming such activities, especially female heads of households. Women’s economic vulnerability creates additional risks of an increase in cases of sexual exploitation and abuse and of early marriage.
Women have less Access to stable Income than men

In Kirkuk, only a quarter of respondents said that they had a stable source of income. Of those without a stable income, three in five are women. Two-thirds of respondents described their level of income as low, and three-quarters of these were women. Sources of income mentioned by respondents in Kirkuk are shown in Figure 11.

In Diyala, 37.5% of respondents said that they had a stable source of income. Of those without, six out of 10 were women. Two-thirds of respondents said that they had a low income, of whom 63% were women. Sources of income for respondents in Diyala are shown in Figure 12.

In Sulaimaniyah, 44% of respondents said that they had a stable source of income. Among the 56% who did not, the majority were women. Three out of ten respondents described their level of income as low, of whom 62.5% were women. Sources of income for respondents in Sulaimaniyah are shown in Figure 13.
Women's incomes are more affected by coronavirus measures

‘Lots of women-headed households who were dependent on small businesses have lost their business, and they will try to sell their assets to support their children and themselves.’46 These words from a male key informant of 39 years old in Kirkuk describe women’s economic vulnerability, and these observations are consistent with the quantitative data collected during the survey.

Seven out of ten respondents in Kirkuk said that coronavirus-related measures, such as lockdown, quarantine, and physical distancing, affected their household’s economic opportunities and livelihoods. Of these, three out of five were women. In Kirkuk three in ten women respondents had an economic activity before the coronavirus outbreak. Only one respondent had been able to maintain this activity since the coronavirus prevention measures had been implemented.

In Diyala, 79% of respondents (62% of them women) said that such measures had had an impact on their livelihoods, and in Sulaimaniyah the figure was 93% (52% of them women).

In Diyala, less than two out of 10 women had had an economic activity before the outbreak, and only one woman had been able to maintain her business.

In Sulaimaniyah, three out of five of respondents (of them women) also reported that women’s access to nutritious food had decreased since the pandemic began. In Diyala, 56% in Diyala and 50% in Sulaimaniyah.

The greater impacts on women’s livelihoods can be explained by the constraints on women’s mobility, which existed before the pandemic and have been exacerbated by it. There are now checkpoints on main roads to control movement. Men manage to avoid these to reach their workplaces by using smaller roads and shortcuts. Women tend to stay on main roads, where they face less risk of being harassed. Women usually have less knowledge of the surrounding area and thus may not know the alternative routes. Finally, women do not walk alone, especially on smaller roads.47

When asked which measures had had a major impact on their livelihoods, most respondents cited the lockdown. For men, it prevents them from going out to work, especially daily workers. Women who previously had an economic activity at home can no longer go out to buy supplies, or supplies are too expensive, or clients can no longer come to buy their products. In Sulaimaniyah, several respondents reported late payment of their government salaries; one said: ‘As the government did not pay salaries on time, we couldn’t buy the necessary items.’48
Decision making around household income

According to Oxfam’s earlier research, financial decisions are generally made jointly between women and men, especially decisions relating to spending on housekeeping, given women’s experience in home economics. A woman’s opinion is seen as more valuable, however, when she is able to secure an income.

In Kirkuk, in 37% of households, wives and husbands decide together how money is spent, and in 29% of households the husband decides alone. It is worth noting that in the 35% of cases where the woman decides, 87% of these are female-headed households. For 14% of respondents, coronavirus has changed decision-making processes in the household. According to respondents who reported such a change, wives and husbands are now more likely to decide on spending together.

In Diyala, half of respondents declared that it was the husband who decided how money was spent in the household. In less than a third of cases, wives and husbands decide together. Two out of ten respondents reported that the wife decides; most of these cases were female-headed households. According to 16% of respondents, coronavirus has changed decision making around spending money, and in more than half of those cases it is now the husband who decides alone.

In Sulaimaniyah, wives and husbands decide together on household spending in 48% of cases, and the husband decides alone in only 26% of cases. According to a large majority of respondents, coronavirus has not affected decision-making processes in their households.

Women have less access to nutritious food

More than one-third of respondents in Kirkuk (36%) do not have access to nutritious food, nine out of ten of these are women. Some 45% of respondents [six out of 10 being women] also reported that their access to nutritious food had decreased since the coronavirus outbreak. Due to the virus, households have less money to buy food (in terms of both quality and quantity), there are fewer options available, and it is more difficult to reach the biggest markets. In response to the question, ‘If nutritious food is lacking in the household, who gets to eat less?’, 48% of respondents said that women would eat less and 45% said that all family members would eat less (of the respondents giving the latter answer, 82% were men).

In Diyala 22.5% of respondents said that they did not have access to nutritious food, and in Sulaimaniyah the figure was 22%. Of respondents who said they did not have access to nutritious food, women accounted for 56% in Diyala and 50% in Sulaimaniyah.

In Diyala three out of five of respondents (of whom 57% were women) also reported that their access to nutritious food had decreased since the pandemic began. Curfews prevent people from working, reducing household income and thus people’s capacity to buy food, and they also prevent them from going out to markets to buy food. In addition, what food is available in the markets is being sold at higher prices, and healthy food is not always available. When nutritious food is lacking, in 49% of cases it is women who eat less, in 30% of cases men, and in 11% of cases all family members.

In Sulaimaniyah, 44% of respondents (58% of them women) said that their access to nutritious food had changed since the pandemic began. In addition to high prices and limited incomes, respondents here also reported the closure of markets and the suspension of mobile shops as measures that prevent them from accessing nutritious food. When such food is lacking, men reportedly eat less in 58% of cases (though 90% of respondents giving this answer were men).
Access to health and sexual and reproductive health services

Stigmatization and discrimination have a major impact on access to Covid-19 health facilities

Some families suspected of bringing the disease to a community have been blamed or ostracized. Stigmatization or fear of stigmatization is affecting access to healthcare, as a key informant (female, age 28) noted: 'In earlier cases, families did not report their family members' infection with COVID-19 as they were afraid of being stigmatized. Some families with infected, or allegedly infected, members have even considered moving to other neighborhoods, especially if the person is a woman. Some girls reported to Oxfam’s local partner organization Iraqi Al-Amal that they were afraid that they would not be able to get married if they became infected with COVID-19. Stigma against infected people varies by gender: while men are pitied, women are usually blamed for doing something wrong.

Local Iraqi media have reported several cases in which families have refused to allow female family members to go into medical quarantine in hospital after testing positive for COVID-19. Medical sources have reported several cases in which relatives of females confirmed to be infected said that they could not let them stay away from home without being accompanied, even in hospital to receive medical treatment, arguing that 'it goes against their customs and traditions'. The GBV Sub-Cluster assessment recorded ‘62 incidents where families denied women and girls access to quarantine or health facilities due to social norms or fears of exposure to GBV risks’.

Several key informants confirmed that women faced difficulties in accessing health services. One (male, age 47) said that they were quarantined in their own homes if they became infected; another (female, age 61) reported: ‘Sometimes it is better [for a woman] to stay at home and for her family to take care of her because maybe people will talk badly about her.’

Another interviewee (female, age 41) said: ‘A lot of families do not allow their female family members to go to hospitals due to norms and traditions. They are also depending on them to do the housework and take care of the children.’

Thousands of people in Iraq lack civil documentation, either because their documents have been confiscated by ISIS or by state security forces, or because they have lost them during displacement. Coronavirus is considered by health authorities to be an emergency and identification is not required to receive care, as confirmed by a male key informant: ‘I had some signs of COVID-19 and went to hospital to check. No one asked me about ID or any other document.’ However, several key informants reported that some people have not sought medical care, fearing that they would be asked for ID at the health facility or at one of the checkpoints on the road on the way there.

People with non-coronavirus needs have difficulties in accessing care

Disruption in access to healthcare has a major impact on people with chronic diseases or those living with disabilities, as they need regular care. According to a female health care provider, some health facilities maintain a register with ‘data and a list of pregnant women, people with chronic diseases who are attending the Primary Health Care Center (PHCC) regularly’. However, the same health professional said: ‘People are really afraid to attend healthcare facilities. They visit only for emergencies.’
Access to sexual and reproductive health services is extremely limited

The recent conflict has devastated health facilities in Iraq. According to the 2020 Humanitarian Needs Overview, 'The partial destruction of many hospitals has led to a markedly reduced access to sexual and reproductive health services, including skilled birth attendance.' Communities’ trust in such services is impaired by a chronic lack of supplies, equipment, and skilled staff, and this is combined with low awareness of the importance of ante-natal monitoring or health facility-based delivery and conservative cultural norms around women’s fertility.

The COVID-19 Strategic Response Plan for Iraq includes an objective of ensuring the continuity of essential services, for instance by ‘establishing synergy and coordination among UN Agencies.’ However, SRH services are not explicitly mentioned in the document.

Healthcare providers taking part in the KIIs reported that SRH supplies were now lacking: one said (female, age 42) ‘Deliveries of medication are late, so we run out of items, especially for women’s health.’

In Kirkuk, no female respondents reported using SRH services, either before or during the coronavirus outbreak. In Diyala, 84% of respondents said that they did not use SRH services prior to the pandemic. Since the outbreak began, this percentage has increased to 94%. Among women who did use SRH services, the team observed a reduction in the number of consultations for family planning; this could lead to more unwanted pregnancies.

Now, women don’t have access to those services anymore. There is a lack of supplies, and women don’t have money to pay for the transport to the PHCC or can’t go out because of the lockdown.’

Iraqi Al-Amal staff member, female, 43 years old, May 10, 2020

There is one PHCC in a community where we are working that used to receive 65 clients per day for sexual and reproductive health consultations.
Recommendations

• Ensure that health facilities provide gender-sensitive services in isolation, sanitation, and treatment facilities. Female staff should be present in quarantine areas, even on night shifts; isolation wards should be segregated by gender; women should have specific hygiene and sanitation facilities, etc.

• Ensure that healthcare providers are aware of GBV referral pathways and are trained on the identification and safe referral of GBV survivors.

• Integrate awareness raising around GBV and information about available services into all WASH activities (such as the distribution of hygiene kits).

For emergency food security and vulnerable livelihoods (EFSVL) programs

• In line with the recommendations of UN Women, prioritize economic support for female-headed households who have been adversely affected by coronavirus, including by increasing their vulnerability to exploitation.

• Integrate awareness raising around GBV and information about available services into all EFSVL activities.

• Provide legal assistance through referral pathways to help vulnerable women obtain the documentation needed to register for support programs.

• Given the economic impacts of coronavirus on both formal and informal markets, inform livelihood interventions with gender analyses and/or gender-based livelihoods and risk assessments.

• Develop targeted programming for women’s economic empowerment, including capacity-building initiatives to mitigate the impacts of the outbreak, support women to recover, and build resilience to future shocks.

• Identify women, especially those in female-headed households and other at-risk groups, and include them in cash and livelihood interventions, in ways that are safe for them to access.
For water, sanitation, and hygiene (WASH) programs

- Ensure that health facilities provide gender-sensitive services in isolation, sanitation, and treatment facilities. Female staff should be present in quarantine areas, even on night shifts; isolation wards should be segregated by gender; women should have specific hygiene and sanitation facilities, etc.
- Ensure that healthcare providers are aware of GBV referral pathways and are trained on the identification and safe referral of GBV survivors.
- Integrate awareness raising around GBV and information about available services into all WASH activities (such as the distribution of hygiene kits).

For emergency food security and vulnerable livelihoods (EFSVL) programs

- In line with the recommendations of UN Women, prioritize economic support for female-headed households who have been adversely affected by coronavirus, including by increasing their vulnerability to exploitation.
- Integrate awareness raising around GBV and information about available services into all EFSVL activities.
- Provide legal assistance through referral pathways to help vulnerable women obtain the documentation needed to register for support programs.
- Given the economic impacts of coronavirus on both formal and informal markets, inform livelihood interventions with gender analyses and/or gender-based livelihoods and risk assessments.
- Develop targeted programming for women’s economic empowerment, including capacity-building initiatives to mitigate the impacts of the outbreak, support women to recover, and build resilience to future shocks.
- Identify women, especially those in female-headed households and other at-risk groups, and include them in cash and livelihood interventions, in ways that are safe for them to access.
For GBV and protection programs

- Strengthen awareness raising around GBV and protection as part of the coronavirus response.
- Provide legal assistance and protection services for vulnerable women.
- Establish mechanisms for the monitoring of protection issues, including gender-specific actions.
- With the support of the GBV Sub-Cluster, develop standard operational procedures (SOPs) to provide medical assistance to GBV survivors.
- Increase coordination and collaboration amongst service providers and ensure that a comprehensive referral system is established and functional.
- Partner with local NGO service providers and ensure that they are adequately supported, both technically and financially.
- Invest in community-based protection and establish committees that can provide services at the local level.
- Provide psychosocial support activities designed as an entry point for the identification and support of GBV survivors and a space for men to learn how to deal with stress and anger.

For awareness-raising activities

- Develop/adapt key messaging in information, education, and communication (IEC) materials to speak to the needs and vulnerabilities of women, men, boys, and girls.
- Translate materials into local languages and adapt them to the local context.
- Include information for pregnant women, people with disabilities, and other vulnerable individuals, including on how and where to seek care, based on their questions and concerns.
- Consider providing specific advice for people—usually women—who care for children, the elderly, and other vulnerable groups and who may not be able to avoid close contact.
- Ensure that information is disseminated as widely as possible, and in innovative ways (radio, TV, SMS, leaflets).
For local governments and decision makers in Iraq

- Build confidence in the official helplines for GBV survivors by investing in promoting them and increasing awareness about available services.
- Make sure that women and girls are involved in decision making around coronavirus and that their needs are adequately taken into account in the response.
- Involve civil society and women’s rights organizations to ensure that women are represented in decision-making processes and aim for gender parity in implementation teams.
- In line with the recommendations of UN Women, ensure that the SRH rights of women and girls continue to be met during the coronavirus crisis.
- Improve the coordination of local authorities with clusters to ensure that they are represented in coordination mechanisms.
- Monitor the long-term socio-economic impact of the pandemic with a gender lens and provide long-term commitment and responses to address deeply gendered inequalities in Iraq and protect women’s rights.

For donors and UN agencies

- Support a gender-sensitive response to the coronavirus pandemic, requiring NGOs to conduct gender analyses and to include specific activities and budgets to address the differing needs of women, girls, men, and boys.
- Increase funding for GBV services, with a focus on women’s centers run by women’s rights organizations.
- Address acute needs, especially in food security, WASH, GBV, and economic resilience.
- Support activities that address social norms and promote the inclusion of women in all programmatic interventions and decision-making processes.
- Strengthen inter-cluster coordination and ensure that sector-specific plans designed by government, local authorities, and other humanitarian actors are gender-sensitive.
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Annex 1

Survey questionnaire

My name is [ENUMERATOR’s name] and I work with Oxfam. I would like to ask you some questions about the COVID-19 outbreak and to understand the concerns and needs of women and girls. General information will be shared within Oxfam and other agencies responsible for organizing services. Your name will not be recorded and your identity will be kept confidential. It will not be possible to trace this interview back to you or your household. Under no circumstances will we share information from this interview with anyone else in your home or your community. Your participation in any future programs will not be influenced at all by any information that you provide. Participation in this survey is voluntary, and if we should come to any question that you do not want to answer, just let me know and I will go on to the next question; or you can stop the interview at any time. This interview will take approximately 20 to 30 minutes. At this time do you have any questions about the survey?

Informed consent

Are you willing to participate in this survey? (If no, ask why and move on to the next household)

a. Yes
b. No

Demographic information about the respondent

Sex:

a. Male
b. Female

Age:

a. 18–24
b. 26–40
c. 40–50
d. 50 or above

Marital status:

a. Married
b. Not married
c. Divorced
d. Widowed

Roles, responsibilities, needs, vulnerabilities

Who is responsible for keeping the house clean and preparing food?

a. The wife
b. The husband
c. Shared responsibility in the family
d. Girl children
e. Boy children
f. Other relatives, please specify

If no, why don’t you have access to these products?

a. Not enough financial resources
b. Products are not available in my area
c. I don’t think they are important products
d. I can’t go out to purchase the products
e. Other, please specify

Survey questionnaire
Who is responsible for care for the children and/or ill people?
- The wife
- The husband
- Shared responsibility in the family
- Girl children
- Boy children
- Other relative, please specify

Who does the shopping for food and other household items?
- The wife
- The husband
- One of the boy children
- One of the girl children
- Other relative, please specify

Access to information

Have you heard of coronavirus?
- Yes
- No

What is your source of information about coronavirus?
- My husband
- My wife
- The neighbours
- Radio
- TV
- Messages from telecommunication companies
- Internet
- Boards on the roads/public buildings
- NGOs
- No information about coronavirus
- Other, please specify

Do you know the prevention measures against coronavirus?
- Yes
- No

Are you able to implement the prevention measures against coronavirus?
- Yes
- No If No: Why not?

Is anyone in your household particularly vulnerable to coronavirus?
- Yes If Yes: Who and why?
- No

Wash

Do you have access to clean water?
- Yes
- No

Do you have access to soap?
- Yes
- No

(Women) Do you have access to menstrual hygiene products?
- Yes
- No

Do you have access to other hygiene products (alcohol, chlorine, other disinfectants)?
- Yes
- No

If no, why don’t you have access to these products?
- Not enough financial resources
- Products are not available in my area
- I don’t think they are important products
- I can’t go out to purchase the products
- Other, please specify

Decision making/leadership

Have you been involved in discussions and decision-making processes about coronavirus in your community?
- Yes
- No

Who is taking decisions related to coronavirus in your family?
- The wife
- The husband
- Shared responsibility in the family
Livelihoods

What is your family’s main source of income?
- Government wages
- Retirement pension
- Husband’s wages/my wages
- My wages/Wife’s wages
- Children’s wages
- Social security benefits
- Assistance from INGOs
- Assistance from relatives
- Selling property
- Cash payments made by MOLSA
- Debt
- Other source, please specify _______________________

2. Do you have a stable source of income?
- Yes
- No

3. How would you categorize the level of your income?
- Low
- Medium
- High

4. Have measures such as lockdown/quarantine/physical distancing affected your household economic opportunities and livelihoods?
- Yes If Yes: Which measures?
- No

5. [Women] Were you able to carry out an economic activity before coronavirus?
- Yes
- No

6. [Women] If yes, have you been able to maintain this activity since coronavirus prevention measures have been implemented?
- Yes
- No

7. Who decides how money is spent?
- Husband decides
- Wife decides
- Wife and husband decide together
- Other relative decides, please specify _______________________

8. Has the coronavirus changed who decides how money is spent?
- Yes
- No

9. If yes, how?
- Now the husband decides alone
- Now the wife decides alone
- Now husband and wife decide together
- Now other person decides, please specify _______________________

Food security

1. Do you have access to nutritious food?
- Yes
- No

2. Has your access to nutritious food changed since the coronavirus outbreak began?
- Yes If Yes, How?
- No

3. If nutritious food is lacking in the household, who gets to eat less?
- Husband
- Boys
- Wife
- Girls
- All family members
- Others, please specify _______________________

Health/sexual and reproductive health rights (multiple answers are possible)

1. Women) Before the coronavirus outbreak, did you use to go to the health facility for:
- Ante-natal control
- Post-natal control
- Contraceptive supplies
- Other gynecological issues
- None of the above
- Other, please specify _______________________

2. Women) Since the coronavirus outbreak, have you been to the health facility for:
- Ante-natal control
- Post-natal control
- Contraceptive supplies
- Other gynecological issues
- None of the above
- Other, please specify _______________________
Gender-based violence

Inform the respondent that you would like to ask some questions about violence against women and girls during the coronavirus epidemic. Explain that you are looking for general information about what is happening in the community during the epidemic and are not asking the person to share personal information nor information related to a specific case that she/he is aware of. Ask the person if she/he feels safe to answer such questions and if she/he agrees to answer these additional four questions.

1. Do you think that women and children face increased protection risks as a result of the coronavirus epidemic?
   a. Yes  If Yes, which risks:
      1) Physical violence
      2) Emotional abuse
      3) Sexual violence
      4) Economic violence
      5) Sexual abuse and exploitation by NGOs
      6) Forced prostitution
      7) Forced marriage
   b. No

2. Do you know where to report violence or get information on services for victims of violence?
   a. Yes
   b. No

3. Are you aware of any mobile hotlines set up in your area to support victims of violence?
   a. Yes
   b. No

4. If a confidential hotline was available in this area, do you think women would use it?
   a. Yes
   b. No
Annex 2

List of key informant interviews

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Age</th>
<th>Date of interview (2020)</th>
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<tbody>
<tr>
<td>1</td>
<td>Civil society organization representative</td>
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<td>2</td>
<td>Healthcare provider</td>
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<td>3</td>
<td>Person participating in Oxfam programme</td>
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<td>4</td>
<td>Person participating in Oxfam programme</td>
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<tr>
<td>5</td>
<td>Community leader</td>
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<td>6</td>
<td>Healthcare provider Mokhtar (religious leader)</td>
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<td>7</td>
<td>Person participating in Oxfam programme</td>
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<td>9</td>
<td>Community leader</td>
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<td>10</td>
<td>Women’s rights organization representative</td>
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<td>11</td>
<td>Community leader Person participating in Oxfam programme</td>
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<td>12</td>
<td>Healthcare provider Community leader</td>
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<td>Women’s rights organization representative</td>
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<td>14</td>
<td>Community leader Community leader</td>
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<td>Healthcare provider</td>
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<td>16</td>
<td>Community leader</td>
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<td>17</td>
<td>Women’s rights organization representative</td>
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<td>Community leader</td>
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<td>Date of interview (2020)</td>
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<tr>
<td>Sulaimaniyah</td>
<td>Female</td>
<td>37</td>
<td>April 29</td>
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</tbody>
</table>
Key informant

**Note:** This tool should be used for discussions with individuals. Make sure you organize the interview in a safe location that allows some privacy and maintain distance between you and the respondent.

**Before starting the interview:**
- Introduce yourself and share general information about Oxfam.
- Explain that the purpose of the interview is to share information on the COVID-19 outbreak and to understand concerns and needs for women and girls.
- General information will be shared within Oxfam and other agencies responsible for organizing services.
- Reassure respondents that all discussion is confidential.
- Ask permission to take notes.

**After the interview:**
- Do not share details of the discussion later.
- Do not share stories that identify individuals.

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**Roles, responsibilities, needs, vulnerabilities**

1. a) What are the different roles and responsibilities (formal and informal) for women, men, boys, and girls in your community?  
   b) How do these vary by age, ability, etc.?  
   c) Are these roles and responsibilities affected by coronavirus? How?

2. a) Do you think that women, girls, men, and boys are at the same risk of contracting COVID-19?  
   b) If no, what is the difference in the risk of contracting COVID-19 for men, women, girls, and boys? How does this vary by age, ability, etc.?  
   c) What are the specific difficulties for children and adults living with disabilities? Note: this question allows us to understand the perceptions of the community on vulnerability and susceptibility to COVID-19.

3. a) Are people allegedly infected by the coronavirus stigmatized in your community?  
   b) If a woman in your community is suspected of being infected by coronavirus, would she be able to go a health facility? Would her family let her be quarantined at a hospital?  
   c) Are families/women suspected of being infected by coronavirus with no documentation accessing health services?

---

**Decision making/leadership**

4. Who is making decisions and leading the COVID-19 response efforts?  
   a) Are both women and men represented in decision making and leadership?  
   b) Are both women and men being consulted and participating in the design of the response?

5. Are women’s rights organizations (WROs), women leaders, and other groups being engaged to participate in the design of the response?

---

**Livelihoods**

6. How is COVID-19 affecting economic opportunities for men and women? Is it different for pregnant women, people with disabilities, elderly women, etc.?

7. Before the COVID-19 pandemic, who controlled resources between men and women at household and community levels? Has this changed since the virus affected your community?

8. How has COVID-19 influenced the time that women, men, girls, and boys spend doing unpaid work at the household or community levels?  
   Prompts: water supply, preparing food, looking for firewood, taking care of the sick, taking care of children, washing clothes, etc.

9. a) How are measures designed to curb transmission of the virus, such as lockdown, quarantine, and physical distancing, affecting economic opportunities and livelihoods?  
   b) Are there any groups that are particularly affected?  
   c) What measures can be put in place to cushion adverse effects, especially on groups likely to be most affected?

---

**Gender-based violence (GBV)**

1. a) Are women, men, boys, and girls at heightened risk of GBV during this crisis? If so, why do you think that this is the case?  
   b) What are the specific risks for each group?  
   c) What can be done to mitigate against or reduce GBV during this crisis?

2. a) Do you know where to report GBV or get information on GBV response services?  
   b) Are you aware of any mobile hotlines set up in your area to respond to GBV?

3. What response mechanisms are in place for survivors of sexual exploitation and abuse?
Guide for KIIs with community leaders and members of community committees, women’s rights organizations, and civil society organizations

Roles, responsibilities, needs, vulnerabilities

1. a) What are the different roles and responsibilities (formal and informal) for women, men, boys, and girls in your community?  
   b) How do these vary by age, ability, etc.?  
   c) Are these roles and responsibilities affected by coronavirus? How?

2. a) Do you think that women, girls, men, and boys are at the same risk of contracting COVID-19?  
   b) If no, what is the difference in the risk of contracting COVID-19 for men, women, girls, and boys? How does this vary by age, ability, etc.?  
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   c) Are families/women suspected of being infected by coronavirus with no documentation accessing health services?

Decision making/leadership

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8. How has COVID-19 influenced the time that women, men, girls, and boys spend doing unpaid work at the household or community levels? Prompts: water supply, preparing food, looking for firewood, taking care of the sick, taking care of children, washing clothes, etc.

9. a) How are measures designed to curb transmission of the virus, such as lockdown, quarantine, and physical distancing, affecting economic opportunities and livelihoods?  
   b) Are there any groups that are particularly affected?  
      Note: women are likely to be more adversely impacted as they dominate micro and small enterprises, the low-skilled workforce, domestic work, migrant work, etc.  
   c) What measures can be put in place to cushion adverse effects, especially on groups likely to be most affected?

Gender-based violence (GBV)

1. a) Are women, men, boys, and girls at heightened risk of GBV during this crisis? If so, why do you think that this is the case?  
   b) What are the specific risks for each group?  
   c) What can be done to mitigate against or reduce GBV during this crisis?

2. a) Do you know where to report GBV or get information on GBV response services?  
   b) Are you aware of any mobile hotlines set up in your area to respond to GBV?

3. What response mechanisms are in place for survivors of sexual exploitation and abuse?
Guide for KII with people participating in Oxfam's or partners' programs

Roles, responsibilities, needs, vulnerabilities
1. a) What are the different roles and responsibilities (formal and informal) for women, men, boys, and girls in your community?
   b) How do these vary by age, ability, etc.?
   c) Are these roles and responsibilities affected by coronavirus? How?

2. a) Do you think that women, girls, men, and boys are at the same risk of contracting COVID-19?
   b) If no, what is the difference in the risk of contracting COVID-19 for men, women, girls, and boys? How does this vary by age, ability, etc.?
   c) What are the specific difficulties for children and adults living with disabilities? Note: this question allows us to understand the perceptions of the community on vulnerability and susceptibility to COVID-19.

3. a) Are people allegedly infected by the coronavirus stigmatized in your community?
   b) If a woman in your community is suspected of being infected with coronavirus, would she be able to go the health facility? Would her family let her be quarantined at the hospital?
   c) Are families or women suspected of being infected by coronavirus with no documentation accessing health services?

Access to information
4. a) Do men, women, boys, and girls in the community have the same access to information about COVID-19 and prevention/response efforts?
   b) If not, who has more access? And how can access to information be improved for all?
   Note: women and girls are less likely to have access to information. Probe: what modes of communication e.g. radio, text messages, etc. can be used to improve access to information?

5. a) How can messaging on COVID-19 be tailored to address the needs, vulnerabilities, and risks of women, men, boys, and girls?
   b) Is information tailored to the needs of pregnant and breastfeeding women, people living with HIV, persons with pre-existing conditions, and older persons?
Coping strategies and capacities
6. a) What are the different mechanisms and strategies that women, men, girls, and boys are using to deal with the COVID-19 crisis?
b) Is there a difference in strategies between men, women, girls, and boys?
    Probe: economic/sexual exploitation of out-of-school children/adolescents, avoiding health centers/healthcare facilities, avoiding care-giving responsibilities especially for the sick.

7. What are the different capacities and opportunities that men, women, girls, and boys have and can utilize to contribute positively to the prevention of and the response to COVID-19?
    Probe: risk management, community/mobilization and awareness raising.
    Note: women’s multiple roles as social mobilizers, contact tracers, information managers (including rumor mitigators), operational/technical experts, community health workers/focal points, etc.

WASH
8. a) Has there been any change in water, hygiene, and sanitation practices since the beginning of the crisis?
b) Are there any notable differences in practices among men, women, girls, and boys?
c) What recommendations do you have relating to hygiene and prevention of COVID-19 transmission?

GBV
9. a) Are women, men, boys, and girls at heightened risk of GBV during this crisis? If so, why do you think that this is the case?
b) What are the specific risks for each group?
c) What can be done to mitigate against or reduce GBV during this crisis?
10. a) Do you know where to report GBV or get information on GBV response services?
b) Are you aware of any mobile hotlines set up in your area to respond to GBV?
11. What response mechanisms are in place for survivors of sexual exploitation and abuse?

Data collection
1. Do you disaggregate data by sex, age, and disability and analyze this desegregation in order to understand differences in terms of infection and mortality rates and possible social factors causing this?

Health/sexual and reproductive health rights
3. What is the impact of the COVID-19 crisis on access to healthcare for women, men, girls, and boys?
4. Do men, women, boys, and girls have access to sexual and reproductive supplies, such as contraception?
5. Do women, men, girls, and boys always have faith in the current health structures or system? If not, why?
6. How has the COVID-19 crisis affected the attendance of women, men, girls, and boys at health facilities?
7. a) What other major specific challenges are faced by adolescent girls and pregnant/lactating women during the COVID-19 crisis?
b) Do pregnant women in quarantined areas have access to care?
8. What local beliefs, attitudes, and practices influence how the health of women/girls and men/boys is affected by the crisis?
    Probe: family planning, pregnancy and childbirth, patient care, greeting, hand washing, fetching and use of water.
9. Do healthcare facilities have an adequate stock of menstrual hygiene products?

GBV
11. a) Are women, men, boys, and girls at heightened risk of GBV during this crisis? If so, why do you think that this is the case?
b) What can be done to mitigate against or reduce GBV during this crisis?

12. Are healthcare workers and frontline social workers trained to recognize signs of domestic violence and to provide appropriate resources and services, including referrals?
13. a) Do you know where to refer/orient GBV cases?
b) Are you aware of any mobile hotlines set up in your area to respond to GBV?

KII:s with Department of Health (DOH) and health facility staff
https://app.powerbi.com/view?r=sv3rlq0Mlj0MDhjYmItZTlhM500MDhLtg3MJlIMDnM2FhNzE5MmE4lwidC6lmY2MTBjMiL3LVJCMj0NGz0S04MTc8LTNLXjZ4MGFmy0U5McFiamjDjD9

https://www.theglobaleconomy.com/iraq/female_labor_force_participation/


https://www.axios.com/china-domestic-violencecoronavirus-quarantine-7b00c3ba-35bc-4d16-afdd-b76ectb28882.html


https://doi.org/10.1080/13552074.2019.1615288


https://www.indexmundi.com/iraq/demographics_profile.html

11. UNDP Iraq. Gender in Focus. 
www.iq.undp.org/content/dam/iraq/docs/Gender_final.pdf


16. Ibid.


18. Halabja and Darbandikhan districts are included here in Sulaimaniyah governorate despite their contested status.

19. The gender analysis initially targeted Kirkuk and Diyala. As the coronavirus pandemic reached Sulaimaniyah, this governorate neighboring Diyala was included and some surveys and KIs were also conducted there.

20. Key informants included community leaders, religious leaders, members of civil society organizations (CSOs) and women’s rights organizations (WROs), healthcare providers, and people with whom Oxfam and partners work in their programs.
Diyala, KII with community leader, male, 47 years old, April 28, 2020.


Diyala, KII with female participating in Oxfam program, 61 years old, April 27, 2020.

Diyala, KII with WR0 representative, female, 50 years old, May 1, 2020.


Economic violence’ means the denial of resources, opportunities or services.


Rapid assessment of the health services response to GBV survivors during the COVID-19 emergency in Iraq, April 2020.

Sulaimaniyah, KII with community leader, male, 36 years old, April 28, 2020.


Ibid.


Diyala, KII with WR0 representative, female, 50 years old, May 1, 2020.


Diyala, KII with WR0 representative, female, 50 years old, May 1, 2020.
Kirkuk, KII with community leader, male, 39 years old, May 1, 2020.

Diyala, validation workshop with Oxfam in Iraq team, May 7, 2020.

Sulaimaniyah, survey respondent, female, 18–24 years old, April 20, 2020.


Diyala, validation workshop with Oxfam in Iraq team, male staff member, 34 years old, May 7, 2020.

Kirkuk, KII with female participating in Oxfam program, 28 years old, April 28, 2020.

Kirkuk, validation workshop with Oxfam in Iraq team, May 10, 2020.


Diyala, KII with community leader, male, 47 years old, April 28, 2020.

Diyala, KII with female participating in Oxfam program, 61 years old, April 27, 2020.

Kirkuk, KII with community leader, female, 41 years old, April 26, 2020.


Sulaimaniyah, KII with community leader, male, 36 years old, April 28, 2020.

Kirkuk, KII with health facility staff member, female, 46 years old, April 29, 2020.


Diyala, KII with health facility staff member, female, 42 years old, April 27, 2020.


Kirkuk, KII with female participating in Oxfam program, 30 years old, April 30, 2020.

Diyala, KII with female participating in Oxfam program, 61 years old, April 27, 2020.

Validation workshop with Oxfam in Iraq team, Diyala, May 7, 2020.


Validation workshop with Oxfam in Iraq team, Diyala, May 7, 2020.

Validation workshop with Oxfam in Iraq and local partner Iraqi Al-Amal, female staff member, 43 years old, May 10, 2020.

Kirkuk, KII with community leader, female, 41 years old, April 26, 2020.

Kirkuk, KII with CSO representative, male, 39 years old, May 1, 2020.

Diyala, KII with WRO representative, female, 50 years old, May 1, 2020.


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Ibid.


Diyala, KII with health facility staff member, female, 42 years old, April 27, 2020.


Ibid.
Acknowledgements

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KEDV (www.kedv.org.tr)